Please complete and return this form along with a copy of your picture identification, $4.55 reproduction of record fee, and a self-addressed stamped envelope to 115 Auditorium Circle, San Antonio, TX. 78205.

San Antonio Fire Department

Patient Authorization for Use or Disclosure of Protected Health Information Form

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security No.: _____

Last Date of Service: _____

I _____, hereby authorize the San Antonio Fire Department to disclose the following protected health information,

San Antonio Fire Department Emergency Medical Services Hospital Report Form

To the following:

San Antonio Fire Department Emergency Medical Services

The purpose for the use and/or disclosure of this protected health information is:

_____

Authorization disclosure termination date: _____

I understand that I may revoke this authorization, in writing, at any time. I understand that my revocation will not be effective to the extent that the authorized entity has relied on the use or disclosure of the protected health information. However, my revocation will be effective from the date of the revocation forward. I understand that information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law.

I acknowledge that I have signed a consent form of the San Antonio Fire Department. I understand that I have the right to inspect or copy my protected health information to be used and/or disclosed as permitted under federal and/or state law. I understand I have the right to refuse to sign this authorization, and in doing so, this authorization will not be effective.

Signature _____ Request Date _____